

HEALTH CARE SUPPLEMENTAL

NAMED INSURED	DBA	EFFECTIVE DATE	
ADDRESS	STATE	CITY	ZIP
WEBSITE ADDRESS	YEARS IN BUSINESS?	ANNUAL REVENUE \$	
ANY ADDITIONAL LOCATIONS?	<input type="radio"/> YES <input type="radio"/> NO		IF YES, DESCRIBE

EXPERIENCE

YEARS EXPERIENCE	OWNER	ADMINISTRATOR	DIRECTOR
YEARS AT FACILITY	OWNER	ADMINISTRATOR	DIRECTOR

DESCRIPTION OF OPERATIONS (CHECK ALL THAT APPLY):

<input type="radio"/> ASSISTED LIVING FACILITY	<input type="radio"/> HOME HEALTH CARE	<input type="radio"/> NURSING HOME	<input type="radio"/> MEDICAL STAFFING AGENCY
<input type="radio"/> PROGRESSIVE LIVING HOME	<input type="radio"/> VETERAN'S HOME	<input type="radio"/> CHILDREN'S HOME	<input type="radio"/> DEVELOPMENT DISABLED HOME

% OF RECEIPTS	PRIVATE PAY	MEDICAID	MEDICARE
	%	%	%
% OF PATIENTS WITH	HEPATITIS	HIV	ALZHEIMER/DEMENTIA
	%	%	%
		MENTAL ILLNESS	CHEMICAL DEPENDENCY
		%	%

EMPLOYEE PROFILE

OCCUPATION	# FULL TIME	# PART TIME	AVERAGE ANNUAL PAYROLL
REGISTERED NURSES			\$
LICENSED PRACTICAL NURSES			\$
CERTIFIED NURSING ASSISTANT			\$
HOUSEKEEPING/MAINTENANCE/LAUNDRY			\$
DIETRY			\$
OFFICE			\$
OTHER (DESCRIBE)			\$

EMPLOYEE SELECTION PROCEDURES

WRITTEN APPLICATION	<input type="radio"/> YES <input type="radio"/> NO	PRE/POST-HIRE PHYSICAL	<input type="radio"/> YES <input type="radio"/> NO
INTERVIEW	<input type="radio"/> YES <input type="radio"/> NO	REFERENCE CHECKS	<input type="radio"/> YES <input type="radio"/> NO
DRUG TEST	<input type="radio"/> YES <input type="radio"/> NO	MVR REVIEW	<input type="radio"/> YES <input type="radio"/> NO
IS SICK TIME PROVIDED?	<input type="radio"/> YES <input type="radio"/> NO	IS VACATION TIME PROVIDED?	<input type="radio"/> YES <input type="radio"/> NO
ARE MEDICAL BENEFITS PROVIDED?	<input type="radio"/> YES <input type="radio"/> NO	% ANNUAL EMPLOYEE TURNOVER?	%

COMPANY VEHICLES (PLEASE PROVIDE COMPANY OWNED VEHICLE LIST.)

# OF COMPANY VEHICLES	# OF DRIVERS	RADIUS OF OPERATIONS
COMMERCIAL AUTO INSURANCE CARRIER	LIABILITY LIMITS \$	# OF EMPLOYEES TRAVELLING IN THE SAME VEHICLE?
ANY PERSONAL VEHICLES USED FOR COMPANY BUSINESS?	<input type="radio"/> YES <input type="radio"/> NO	PROOF OF INSURANCE OBTAINED?
		LIABILITY LIMITS \$

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PLEASE COMPLETE ALL OF THE FOLLOWING

DO YOU HAVE A FORMAL SAFETY PROGRAM?	<input type="radio"/> YES <input type="radio"/> NO
IS THE INSURED COMMITTED TO AN EARLY RETURN TO WORK PROGRAM?	<input type="radio"/> YES <input type="radio"/> NO
IS THE APPLICANT ASSOCIATED WITH A RELIGIOUS ORGANIZATION?	<input type="radio"/> YES <input type="radio"/> NO
ANY DRUG, ALCOHOL, ADDICTION COUNSELING OR SERVICES TO: JAILS, CORRECTIONAL, OR DETENTION CENTERS?	<input type="radio"/> YES <input type="radio"/> NO
IN REVIEWING LOSS HISTORY OF THE APPLICANT, IS THERE ANY EVIDENCE OF VIOLENCE TOWARDS STAFF OR RESIDENTS?	<input type="radio"/> YES <input type="radio"/> NO
ARE SERVICES PROVIDED IN CITIES WITH A POPULATION GREATER THAN 200,000?	<input type="radio"/> YES <input type="radio"/> NO
IS THE APPLICANT A NEW VENTURE OR AN ACQUISITION OF AN EXISTING OPERATION?	<input type="radio"/> YES <input type="radio"/> NO
DOES THE APPLICANT HAVE A CORPORATE BROCHURE? (PLEASE INCLUDE A COPY)	<input type="radio"/> YES <input type="radio"/> NO

HOME HEALTH/ASSISTED LIVING SECTION (IF APPLICABLE)

ANY SKILLED NURSING CARE (NOT INCLUDING: BLOOD PRESSURE, TEMPERATURE, DISPENSING MEDICATIONS?)	<input type="radio"/> YES <input type="radio"/> NO		
IF YES, PLEASE DESCRIBE WHAT IS PERFORMED?			
% OF CLIENTS: AMBULATORY? %	WHEELCHAIRS? %	REQUIRES ASSISTANCE GETTING IN/OUT OF BED, TUB, ETC.?	%
DOES THE APPLICANT PROVIDE ANY TRANSPORTATION SERVICES FOR THE CLIENTS? (DOCTOR APPOINTMENTS, SHOPPING, ETC.)	<input type="radio"/> YES <input type="radio"/> NO		
DO VEHICLES THAT CARRY/TRANSPORT NON-AMBULATORY CLIENTS/PATIENTS USE A LIFTGATE?	<input type="radio"/> YES <input type="radio"/> NO		
ANY "LIVE IN" CARE OR 24 HOUR CARE?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, HOW MANY HOURS ARE THE SHIFTS?	HOURS
FOR ASSISTED LIVING	# OF BEDS	OCCUPANCY RATE %	%

NURSING HOME SECTION (IF APPLICABLE)

TOTAL # OF BEDS	# SKILLED NURSING BEDS	# INTERMEDIATE BEDS	
# ASSISTED LIVING BEDS	# RESIDENTIAL CARE BEDS	OCCUPANCY RATE	
NURSE TO PATIENT RATIO	1 ST SHIFT	2 ND SHIFT	3 RD SHIFT
IS THIS FACILITY: <input type="radio"/> UNION <input type="radio"/> NON-UNION	STATE LICENSED? <input type="radio"/> YES <input type="radio"/> NO	SURVEY DATE?	
DOES THE APPLICANT PROVIDE ANY TRANSPORTATION SERVICES FOR THE CLIENTS? (DOCTOR APPOINTMENTS, SHOPPING, ETC.)			
DO VEHICLES THAT CARRY/TRANSPORT NON-AMBULATORY CLIENTS/PATIENTS USE A LIFTGATE?			

LIST ALL RESIDENT TRANSFER AIDS:

TYPE OF DEVICE	#	TYPE OF DEVICE	#

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, or VT. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

INSURED SIGNATURE:	AGENT SIGNATURE:
DATE:	DATE: